MEDICAID SCL WAIVER ASSESSMENT

SECTION I – RECIPIENT DEMOGRAPHICS

Name *(last, first, middle)*	Date of birth *(mo., day, yr.)* / /	Medicaid number
Street address	County code / Sex *(check one)* ☐Male ☐Female	Marital status *(check one)* ☐Divorced ☐Married ☐Separated ☐Single ☐Widowed
City, state and zip code	Emergency contact *(name)*	Emergency contact *(phone #)* ( ) -
Recipient phone number ( ) -	Is recipient able to read and write ☐Yes ☐No	Recipient's height Recipient's weight

SECTION II – RECIPIENT WAIVER ELIGIBILITY

Type of program applied for *(check one)* ☐ Support for Community Living ☐ Consumer Directed Option	Adjudicated____/Nonadjudicated_____ Type of application *(check one)* ☐ Certification ☐ Re-certification
Recipient admitted from *(check one)* ☐Home ☐Hospital ☐Nursing facility ☐ ICF/MR ☐Other_____	Certification period *(enter dates below)* Begin date / / End date / / Cert. # _____
Has recipient's freedom of choice been explained and verified by a signature on the MAP 350 Form ☐Yes ☐No	Has recipient been informed of the process to make a complaint ☐Yes ☐No (*see instructions*)

Physician's name	Physician's license number (enter 5 digit #)	Physician's phone number ( ) -

Enter recipient diagnosis(es):
AXIS I: _____
AXIS II: _____
AXIS III: _____
AXIS IV: _____
AXIS V:

SECTION III – PROVIDER INFORMATION

Provider name	Provider number	Provider phone number ( ) -
Street address	City, state and zip code	
Provider contact person		

SECTION IV – ACTIVITIES OF DAILY LIVING

1) Is recipient independent with **dressing/undressing** ☐Yes ☐No*(If no, check below all that apply and comment)* ☐ Requires supervision or verbal cues ☐ Requires hands-on assistance with upper body ☐ Requires hands-on assistance with lower body ☐ Requires total assistance	Comments:

Name *(last, first):*	Medicaid Number:
2) Is recipient independent with **grooming** ☐Yes ☐No*(If no, check below all that apply and comment)* ☐ Requires supervision or verbal cues Requires hands-on assistance with ☐ oral care ☐shaving ☐ nail care ☐hair ☐ Requires total assistance	Comments:
3) Is recipient independent with **bed mobility** ☐Yes ☐No *(If no, check below all that apply and comment)* ☐ Requires supervision or verbal cues ☐ Occasionally requires hands-on assistance ☐ Always requires hands-on assistance ☐ Bed-bound	Comments:
4) Is recipient independent with **bathing** ☐Yes ☐No *(If no, check below all that apply and comment)* ☐ Requires supervision or verbal cues ☐ Requires hands-on assistance with upper body ☐ Requires hands-on assistance with lower body ☐ Requires Peri-Care ☐ Requires total assistance	Comments:
5) Is recipient independent with **toileting** ☐Yes ☐No *(If no, check below all that apply and comment)* ☐ Bladder incontinence ☐ Bowel incontinence ☐ Occasionally requires hands-on assistance ☐ Always requires hands-on assistance ☐ Requires total assistance	Comments:
6) Is recipient independent with **eating** ☐Yes ☐No *(If no, check below all that apply and comment)* ☐ Requires supervision or verbal cues ☐ Requires assistance cutting meat or arranging food ☐ Partial/occasional help ☐ Totally fed (by mouth) ☐ Tube feeding (type and tube location)	Comments:
7) Is recipient independent with **ambulation** ☐Yes ☐No *(If no, check below all that apply and comment)* ☐ Dependent on device ☐ Requires aid of one person ☐ Requires aid of two people ☐ History of falls (number of falls, and date of last fall)	Comments:
8) Is recipient independent with **transferring** ☐Yes ☐No *(If no, check below all that apply and comment)* ☐ Requires supervision or verbal cues ☐ Hands-on assistance of one person ☐ Hands-on assistance of two people ☐ Requires mechanical device ☐ Bedfast	Comments:

Name *(last, first)* :	Medicaid Number :
SECTION V - INSTRUMENTAL ACTIVITIES OF DAILY LIVING	
1) Is recipient able to prepare **meals** ☐Yes ☐No *(If no, check below all that apply and explain in the comments)* ☐ Arranges for meal preparation ☐ Requires supervision or verbal cues ☐ Requires assistance with meal preparation ☐ Requires total meal preparation	Comments:
2) Is recipient able to **shop** independently ☐Yes ☐No *(If no, check below all that apply and explain in the comments)* ☐ Arranges for shopping to be done ☐ Requires supervision or verbal cues ☐ Requires assistance with shopping ☐ Unable to participate in shopping	Comments:
3) Is recipient able to perform light **housekeeping** ☐Yes ☐No *(If no, check below all that apply and explain in the comments)* ☐ Arranges for light housekeeping duties to be performed ☐ Requires supervision or verbal cues ☐ Requires assistance with light housekeeping ☐ Unable to perform any light housekeeping	Comments:
4) Is recipient able to perform heavy **housework** ☐Yes ☐No *(If no, check below all that apply and explain in the comments)* ☐ Arranges for heavy housework to be performed ☐ Requires supervision or verbal cues ☐ Requires assistance with heavy housework ☐ Unable to perform any heavy housework	Comments:
5) Is recipient able to perform **laundry** tasks ☐Yes ☐No *(If no, check below all that apply and explain in the comments)* ☐ Arranges for laundry to be done ☐ Requires supervision or verbal cues ☐ Requires assistance with laundry tasks ☐ Unable to perform any laundry tasks	Comments:
6) Is recipient able to plan/arrange for pick-up, delivery, or some means of gaining possession of **medication(s)** and take them independently ☐Yes ☐No *(If no, check below all that apply and explain in the comments)* ☐ Arranges for medication to be obtained and taken correctly ☐ Requires supervision or verbal cues ☐ Requires assistance with obtaining and taking medication correctly ☐ Unable to obtain medication and take correctly	Comments:

Name *(last, first)* :	Medicaid Number :
7) Is recipient able to handle **finances** independently ☐Yes ☐No *(If no, check below all that apply and explain in the comments)* ☐ Arranges for someone else to handle finances ☐ Requires supervision or verbal cues ☐ Requires assistance with handling finances ☐ Unable to handle finances	Comments:

SECTION VI-MENTAL/EMOTIONAL

1) Does recipient exhibit **behavior** problems ☐Yes ☐No *(If yes, check below all that apply and explain the frequency in comments)* ☐ Disruptive behavior ☐ Agitated behavior ☐ Assaultive behavior ☐ Self-injurious behavior ☐ Self-neglecting behavior	Comments:
2) Is the recipient diagnosed with one of the following: ☐Yes ☐No *(If yes, check below and comment)* ☐ Mental Retardation (Date-of-onset / /) ☐ Developmental Disability (Date-of-onset / /) ☐ Mental Illness (Date-of-onset / /)	IQ Score: If no IQ score available, provide evidence of cognitive impairment from the other assessments (include dates administered)
3) Has recipient experienced a major change or crisis within the past twelve months ☐Yes ☐No (*If yes, describe*)	Description:
4) Is the recipient actively participating in social and/or community activities ☐Yes ☐No (*If yes, describe*)	Description:

SECTION VII-CLINICAL INFORMATION

1) Is recipient's **vision** adequate *(with or without glasses)* ☐Yes ☐No ☐Undetermined *(If no, check below all that apply and comment)* ☐ Difficulty seeing print ☐ Difficulty seeing objects ☐ No useful vision	Comments:
2) Is recipient's **hearing** adequate *(with or without hearing aid)* ☐Yes ☐No ☐Undetermined *(If no, check below all that apply, and comment)* ☐ Difficulty with conversation level ☐ Only hears loud sounds ☐ No useful hearing	Comments:

Name *(last, first)* :	Medicaid Number :
3) Is recipient able to **communicate** needs ☐Yes ☐No *(If no, check below all that apply and comment)* ☐ Speaks with difficulty but can be understood ☐ Uses sign language and/or gestures ☐ Inappropriate context ☐ Unable to communicate	Comments:
4) Does recipient maintain an adequate **diet** ☐Yes ☐No *(If no, check all that apply and comment)* ☐ Uses dietary supplements ☐ Requires special diet (low salt, low fat, etc.) ☐ Refuses to eat ☐ Forgets to eat ☐ Tube feeding required *(Explain the brand, amount, and frequency in the comments section)*	Comments:
5) Does recipient require routine lab work ☐Yes ☐No *(If yes, what type and how often)*	Comments:
6) Does recipient require specific, physician-ordered vital signs evaluation necessary in the management of a condition(s) ☐Yes ☐No *(If yes, explain in the comments section)*	Comments:
7) Does recipient have total or partial paralysis ☐Yes ☐No *(If yes, list limbs affected and comment)*	Comments:
8) Does recipient require assistance with changes in body position ☐Yes ☐No *(If yes, check all that apply and comment)* ☐ To maintain proper body alignment ☐ To manage pain ☐ To prevent further deterioration of muscle/joints/skin	Comments:

9) Does recipient require 24 hour caregiver ☐Yes ☐No

10) Does recipient require respite services ☐Yes ☐No *(If yes, how often)*

11) Drug allergies *(list)*	**12)** Other allergies *(list)*

13) Does the recipient use any medications ☐Yes ☐No *(If yes, list below)*

Name of medication	**Dosage/Frequency/Route**	**Administered by**

Name *(last, first)* :	Medicaid Number :

SECTION VIII-ENVIRONMENT INFORMATION

1) Answer the following items relating to the recipient's physical environment *(Comment if necessary)*

Sound dwelling	☐Yes	☐No
Adequate furnishings	☐Yes	☐No
Indoor plumbing	☐Yes	☐No
Running water	☐Yes	☐No
Hot water	☐Yes	☐No
Adequate heating/cooling	☐Yes	☐No
Tub/shower	☐Yes	☐No
Stove	☐Yes	☐No
Refrigerator	☐Yes	☐No
Microwave	☐Yes	☐No
Telephone	☐Yes	☐No
TV/radio	☐Yes	☐No
Washer/dryer	☐Yes	☐No
Adequate lighting	☐Yes	☐No
Adequate locks	☐Yes	☐No
Adequate fire escape	☐Yes	☐No
Smoke alarms	☐Yes	☐No
Insect/rodent free	☐Yes	☐No
Accessible	☐Yes	☐No
Safe environment	☐Yes	☐No
Trash management	☐Yes	☐No

2) Provide an inventory of home adaptations **already present** in the recipient's dwelling. *(Such as wheelchair ramp, tub rails, etc.)*

SECTION IX – HOUSEHOLD INFORMATION

1) Does the recipient live alone ☐Yes ☐No

If yes, does the recipient receive any assistance from others ☐Yes ☐No *(Explain)*

_____
_____
_____
_____
_____
_____
_____

Household Members *(Fill in household member info below)*

a) Name	Relationship	Age	Are they functionally able to provide care ☐Yes ☐No *(If no, explain in the comments section)*
Comments:	Care provided/frequency		

Name *(last, first)* :

Medicaid Number :

b) Name	Relationship	Age	Are they functionally able to provide care ☐Yes ☐No *(If no, explain in the comments section)*
Comments:	Care provided/frequency		
c) Name	Relationship	Age	Are they functionally able to provide care ☐Yes ☐No *(If no, explain in the comments section)*
Comments:	Care provided/frequency		
d) Name	Relationship	Age	Are they functionally able to provide care ☐Yes ☐No *(If no, explain in the comments section)*
Comments:	Care provided/frequency		

SECTION X-CONSUMER DIRECTED OPTION

1) Has the recipient chosen Consumer Directed Option: ☐Yes ☐No

If Yes, has the Rights and Responsibility form (MAP 071) been explained and signed: ☐Yes ☐No

2) Does the Recipient need a Representative: ☐Yes ☐No

If Yes, has the Representative Designation form (MAP 070) been signed: ☐Yes ☐No

SECTION XI-ADDITIONAL SERVICES

1) Has the recipient had any hospital, nursing facility, or ICF/MR admissions in the past 6 months ☐Yes ☐No

(If yes, please list below)

a-Facility name	Facility address	
Reason for admission	Admission date / /	Discharge date / /
b-Facility name	Facility address	
Reason for admission	Admission date / /	Discharge date / /

2) Does the recipient receive services from other agencies *(Example: EPSDT, Aging programs, Meals on Wheels, Community action, etc.)* ☐Yes ☐No

(If yes, list services already provided and to be provided in accordance with a plan of care by an agency/organization, include Adult Day Health Care)

a-Service(s) received	Agency/worker name	Phone number ( ) -

Name *(last, first)* :	Medicaid Number :

Agency address		Frequency	Number of units
b-Service(s) received		Agency/worker name	Phone number ( ) -
Agency address		Frequency	Number of units
c-Service(s) received		Agency/worker name	Phone number ( ) -
Agency address		Frequency	Number of units
3) Is the recipient receiving traditional home health services ☐Yes ☐No *(If yes, list below all traditional home health services that are covered by Medicare/Medicaid/Third Party Insurance)*		Anticipated home health discharge date	
a-Service(s) received	Visits per week/month _____ ☐ Per week ☐ Per month	Type of coverage *(Check all that apply)* ☐ Medicare ☐ Medicaid ☐Private Insurance ☐ Private Pay	
b-Service(s) received	Visits per week/month _____ ☐ Per week ☐ Per month	Type of coverage *(Check all that apply)* ☐ Medicare ☐ Medicaid ☐Private Insurance ☐ Private Pay	
c-Service(s) received	Visits per week/month _____ ☐ Per week ☐ Per month	Type of coverage *(Check all that apply)* ☐ Medicare ☐ Medicaid ☐Private Insurance ☐ Private Pay	

4) Summary for *(check only one)* ☐ Certification ☐ Amendment/Modification

Signature: Date / /

5) Support Coordinator performing assessment or reassessment:

Signature:	Title:	Date / /
Signature:	Title:	Date / /

6) PRO Signature:	Date / /	Approval dates From: / / To: / /